

NSHCF CHARITABLE FUND DISTRIBUTION APPLICATION

North Shore Health Care Foundation
P.O. Box 454, Grand Marais, MN 55604
Phone/FAX: 387-9076

Organization Information

Legal Name of Organization		Date of Application
Address		
City, State, Zip		
Telephone/Fax		Email
Individual(s) Responsible	Contact Person's Title	Telephone
Organization Description		
Is your organization an IRS 501c3 not-for-profit? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If no, is your organization a public agency/unit of government or religious institution? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If no, name of fiscal agent:		

Amount and Type of Support Requested

The dollar amount being requested: \$
Funds are being requested for:
Other sources of funding: \$
Other organizations you have contacted for funding:
If a project, give project duration: _____ Month _____ Year to _____ Month _____ Year

Budget

Total annual organization budget: \$	Total project budget: \$
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Proposal Summary

Project Name:
Please give a 2-3 sentence summary of the request: (attach separate sheet if necessary)
Geographic area served:
Population served:
AUTHORIZED BY (please print)

Updated(7/2006)